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IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

Petitioner,

v.

THE HONORABLE JOHN SPERONI, TAMMY SNIDER and MICHAEL AVERY,

Respondents.

On Petition for Writ of Certiorari to the Illinois Supreme Court

BRIEF OF AMICUS CURIAE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS IN SUPPORT OF THE PETITION FOR CERTIORARI

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BRIEF OF AMICUS CURIAE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS IN SUPPORT OF THE PETITION FOR CERTIORARI

This matter concerns a nationwide class action for damages based upon the application of one state's consumer fraud statute to insurance practices in 47 other states. The underlying misconduct alleged relates to a practice that insurance regulators in some of these 47 states allow or even require, but that insurance regulators in other states restrict.

The National Association of Insurance Commissioners ("NAIC"), whose members are the chief state insurance regulators, is committed to the protection of insurance consumers in each of the 50 states and territories. The NAIC supports the use of class action lawsuits brought by insurance consumers under certain conditions, and wishes clearly to state that its appearance as *amicus* for the Petitioner does not indicate a general opposition to all class actions brought by insurance consumers. Instead, the NAIC appears to apprise the Court of its opposition to this particular class action for a single reason. If it is condoned and if plaintiffs prevail, the fundamental regulatory structure embodied in the McCarran-Ferguson Act, under which the regulation of insurance is committed to each of the several states, could be threatened: for the court in the class action forum state, Illinois, could override policy decisions that legislators and insurance regulators in other states have made, based upon their views of the needs and interests of insurance consumers who reside in their own states.

INTEREST OF THE AMICUS CURIAE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS[1]

The NAIC is a voluntary unincorporated association comprised of the insurance regulatory officials with principal responsibility for supervising the business of insurance in the states, territories and insular possessions of the United States. The organization aims to help state officials achieve fundamental insurance regulatory objectives. Of overriding importance in all its activities is the protection of insurance consumers.

The NAIC believes that protection of insurance consumers is best achieved where each state regulates the policyholder-insurer relationship in accord with the unique needs of its residents. In many areas, such as solvency protections, state regulators have chosen to adopt uniform laws, and they work together, directly and through the NAIC, to enforce them. In other respects, however, the states historically have taken different paths to respond to particular geographic and economic conditions, as well as differing regulatory philosophies.

Although the NAIC provides a forum in which the states may coordinate and, where appropriate, promulgate uniform regulations, the needs and interests of

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[1] The parties have consented to the filing of this brief. Copies of the letters of consent have been lodged with the Clerk of the Court. This brief was not authored in whole or in part by counsel for a party, and no person or entity, other than the *amicus curiae*, their members, and their counsel, made a monetary contribution to the preparation and submission of this brief.

insurance consumers may vary significantly from state to state. For example, insurance consumers in California have obvious special insurance needs arising from the risk of earthquakes; Florida consumers have special needs arising from hurricane risk; tornados are of special concern for midwestern consumers. With respect to health, insurance regulators or legislators in one state may conclude that its residents have a particularized need for certain benefits, which are then mandated, while the regulators and legislators in neighboring states may determine that such benefits should be optional in order to keep premium levels more affordable.

The NAIC views decisions about such matters as ones that should be left to each state. Therefore, where an insurance regulator in one state has regulated a specific aspect of the insurer-policyholder relationship as applied to that state's own residents, the NAIC believes that the insurance regulatory system is best served when that regulation is respected by sister states. Accordingly, where a court in a sister state applies the sister state's substantive law of consumer fraud to the first state's regulation in a dispute involving the first state's residents, the sister state's court threatens the effective protection of the residents in the first state by countermanding the regulatory processes and judgments of the first state.

The class action in which this appeal arises involves the repair of automobiles after an accident, and specifically, the use of replacement parts. The term "Non-Original Equipment Manufacturer (non-OEM) parts" refers to those parts made by other than the original manufacturer. The several states differ in their ap-

proaches to regulation of the use of non-OEM parts for repairing insured vehicles. These differences reflect the considered judgment of the state legislators and regulators in each state as to the best interests of its own residents.

States differ in their regulation of the use of non-OEM parts generally because different regulators have assigned different value to competing considerations: the cost of repair, the impact of those costs on insurance premiums, and judgments about the quality of repair. In other words, some states favor use of non-OEM parts because of the perceived cost savings. Others disfavor such use, valuing more highly other factors, such as the quality of the OEM part.

The NAIC takes no position here about these judgments, other than to remind that under the law each state is vested with the power to make such judgments for the residents of its own state, and to make different judgments than its sister states. In order that this power be preserved, the NAIC urges reversal of the trial court's order certifying a nationwide class of insurance consumers, because the legality of Petitioner's conduct with regard to the use of non-OEM parts in each of the several states should not be judged under the standards of Illinois' Consumer Fraud Act.

ARGUMENT

The constitutional limitations on choice of law in nationwide class actions have been clearly delineated. Where there are conflicts between and among the substantive laws of the class members' home states and the substantive law of the forum state, imposition of the

forum state's law is not permitted, unless the forum state has a "'significant contact or significant aggregation of contacts' to the claims asserted by each member of the plaintiff class." *Phillips Petroleum Co. v. Shutts*, 472 U.S. 797, 821-22 (1985) (quoting from *Allstate Ins. Co. v. Hague*, 449 U.S. 302, 312-313 (1981)). This principle preserves the federal system by protecting the "autonomy of individual States within their respective spheres." *BMW of North America v. Gore*, 517 U.S. 559, 571 (1996) ("[A] State may not impose economic sanctions on violators of its laws with the intent of changing the tortfeasors' lawful conduct in other States." *Id.* at 572).

Here, the Illinois trial court held that it would apply the substantive provisions of Illinois' Consumer Fraud Act ("the CFA") to Petitioner's practices regarding use of non-OEM parts in 48 different states. Section 10a of the CFA, 815 Ill. Comp. Stat. 505/10a, provides a private cause of action for damages to individual consumers (including insurance consumers), for unfair or deceptive acts or practices. *E.g., Elder v. Coronet Ins. Co.*, 558 N.E.2d 1312, 1319 (Ill. App. Ct. 1990). Prevailing plaintiffs are allowed compensatory and, where appropriate, punitive damages, costs and attorney's fees. 815 Ill. Comp. Stat. 505/10a (1998).

However, the fact is that the insurance regulators in the several different states have promulgated varying regulations for use of non-OEM parts, as Petitioner details in note 7 at page 12 of its Petition For A Writ Of Certiorari. Some of these regulations vary materially from the parallel Illinois regulation. Massachusetts, for example, mandates the use of non-OEM parts in situations where Illinois conditionally allows it. *Compare*

Mass. Regs. Code tit. 211, § 133.04 (1998) *to* 215 Ill. Comp. Stat. 5/155.29 (1998). Nevertheless, if this class action is allowed to proceed, the finder of fact could well conclude that Petitioner's use of non-OEM parts in Massachusetts for Massachusetts insureds was "unfair" or "deceptive" within the meaning of Illinois' CFA.

A CFA action based on "unfairness" requires proof of a practice that, although not unlawful, offends public policy, is oppressive, and causes substantial injury. *Elder v. Coronet Ins. Co.*, 558 N.E.2d 1312, 1318-1319 (Ill. App. Ct. 1990) (denial of an insurance claim based on the results of a polygraph test may be "unfair" within the meaning of the CFA). A CFA action based on "deception" requires proof of a deceptive act or practice, made in the course of trade or commerce, with the intent that the plaintiff rely on the deception. *Siegel v. Levy Organization Dev. Co.*, 607 N.E.2d 194, 198 (Ill. 1992). The fact that the use of non-OEM parts comports with Massachusetts insurance regulations does not appear to mean that the use of them is not "unfair" to Massachusetts insurance consumers, or that those consumers cannot have been "deceived" by the conduct. And if the trier of fact finds unfairness or deception, the Massachusetts class members will be entitled to damages, and potentially other relief allowed under the CFA.

Surely such a result would be inconsistent with *Phillips Petroleum*, for there are no contacts, much less a "significant aggregation of contacts" between Massachusetts insurance consumers, whose cars were damaged and repaired in Massachusetts, and Illinois. Moreover, and ultimately more ominously, the precedent set by allowing such a nationwide class action to proceed

threatens to undermine our system of state-by-state insurance regulation, along with the overall protection of insurance consumers that state-by-state regulation aims to protect.

Use of non-OEM parts is only one of literally hundreds of examples of significant matters on which insurance regulations vary between the states. Each of the differing regulations reflects that state's view of the best interests of insurance consumers within its own borders, taking into account all relevant factors, including the specific needs of the state's insured population as well as the cost and availability of insurance.

Consider, as just one example, the different states' regulatory provisions for mandated health benefits. Some but not all states require coverage of the following treatments or conditions: off-label drug use for AIDS treatment; wigs for hair loss due to medical treatment or injury; in vitro fertilization; care for Alzheimer's disease (including nursing home care); treatment for autism; treatment of TMJ (temporomandibular joint disorders) as a medical (and not dental) disorder; prostate cancer screening; annual, routine health exams and well-baby care; reconstructive surgery after mastectomies. *See*, Appendix: Excerpts from *Mandated Benefits*, NAIC Compendium of State Laws on Insurance Topics (1998). Illinois happens to mandate coverage for reconstructive surgery after mastectomies; Indiana does not. Clearly an Illinois jury should not be given the power to decide whether an Indiana insurer that does not provide such a benefit has committed an "unfair" act that exposes it to compensatory and punitive damages. Yet, if the trial court's decision below is allowed to stand and assuming the Indiana insurer is subject to the jur-

isdiction of an Illinois court, there is no legal barrier to entrusting that delicate question, which should be entirely dependent upon Indiana's public policy determinations, to an Illinois jury sitting in a nationwide class action charging a violation of Illinois' CFA.

The NAIC recognizes that in certain instances the nationwide class action lawsuit is a significant and useful tool for protecting consumer rights apart from the administrative or regulatory remedies available through state insurance departments. Unfortunately, there is no shortage of examples of misconduct in the operation of insurance companies that is plainly prohibited in every state. *See*, *e.g.*, *United States v. Christopher*, 142 F.3d 46 (1st Cir. 1998) (defendant deceived insurance regulators in order to gain control of and loot the assets of insurance companies); *Clark v. Milam*, 872 F. Supp. 307 (S.D.W.V. 1994) (defendants misstated material information on publicly filed financial statements in order to conceal the fact that they were illegally siphoning funds out of insurer); *United States v. Blumeyer*, 114 F.3d 758 (8th Cir. 1997) (defendant engaged in deceptive transactions to conceal the insolvency of insurance company); *Schacht v. Brown*, 711 F.2d 1343 (7th Cir.), *cert. denied*, 464 U.S. 1002 (1983) (same).

But the nationwide class action suit here attacks conduct that is clearly allowed in some states, because the state legislators or regulators in those states determined that allowing the conduct was in its residents' best interest. Such decisions must not be exposed

to second-guessing by courts and juries in another state, particularly where the insurance contracts at issue were sold in and purchased by residents in states where such conduct is allowed. In short, if this nationwide class action is allowed to proceed, it could establish a precedent that would undermine our system of state-by-state insurance regulation, as the laws of particular states are trumped or re-trumped in patchwork fashion in nationwide class actions that attack, as this class action attacks, insurer conduct that is treated differently by the different states.

CONCLUSION

For all these reasons the NAIC respectfully urges that the Court grant the Petition for Certiorari.

Respectfully submitted,

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APPENDIX

Excerpts from NAIC's Compendium of State Laws on Insurance Topics

MANDATED BENEFITS

Over the past several years there has been increasing interest in a topic generally known as "mandated benefits." This term actually covers three subtopics:

(1) Statutes and rules requiring that certain persons be covered by health insurance policies. A good example is the Model Newborn Children Bill (Model #155 in the NAIC *Model Laws, Regulations and Guidelines*) endorsed by the NAIC in 1973. This statute requires inclusion of newly born children in the family policies of their parents from the moment of birth.

(2) Statutes and rules mandating certain illnesses or procedures be covered by health insurance policies. A good example is the Health Examination Benefits Availability Act (Model #160 in the NAIC *Model Laws, Regulations and Guidelines*) adopted in 1986. It requires offering coverage for routine physical examinations and well-baby care.

(3) Statutes and rules mandating that care by certain providers must be reimbursed if it is a covered expense. For example, in some states a statute provides that insurers must cover treatments provided by chiropractors if they would cover those same treatments provided by a medical doctor, and the chiropractor is acting within the scope of his license.

In addition to the types of mandates listed above, statutes vary in whether the coverage specified is *required* to be included in the policy or certificate, or whether it must be *offered* to the subscribers, usually with an increased cost.

This chart will focus on the second classification enumerated. State statutes or regulations providing that certain coverage must be included or offered are summarized on the following pages. A number of different coverages are required in numerous states, while a few are unique to only one or two states.

MANDATED BENEFITS:
PROSTATE CANCER SCREENINGS

STATE	CITATION	SUMMARY
CO	§ 10-16-104	Provide coverage for prostate cancer screening.
GA	§§ 33-29-3.2 (indiv.); 33-30-4.2 (group)	Annual prostate cancer screening for males 45 years of age and older, or 40 years of age and older when ordered by physician. Deductibles and exclusions subject to commissioner approval.
IL	215 ILCS 5/356u	Annual digital rectal examination and prostate-specific antigen tests upon recommendation of full-licensed physician for (a) asymptomatic men 50 and over, (b) African-American men 40 and over, (c) men 40 and over with family history of prostate cancer.
LA	§ 215.11	Coverage for detection of prostate cancer for men over age 50 and as medically necessary for men over 40. Prostate cancer testing applies to contracts issued on or after 1/1/98. Does not apply to individually underwritten plans.

STATE	CITATION	SUMMARY
NJ	17:48E-35.13 (group health serv. corp.) 17:48-6p (group hosp. serv. corp.) 17:48A-7n (group medical serv. corp.) 17B:27-46.10 (group)	Group plans must cover annual diagnostic exam, including digital rectal exam and a prostate specific antigen test for men age 50 and over and for men age 40 and over who have a family history or other prostate cancer risk factors.
NC	58-51-58	Prostate-specific antigen (PSA) test coverage with same deductibles and coinsurance as other procedures.
ND	§ 26.1-36-09.1; SB 2115 (1997)	Annual digital rectal exam and prostate-specific antigen test for males 50 and over, black males 40 and over, 40 and over if family history of prostate cancer.
TX	art. 3.70-2(H); art. 21.53F	Annual diagnostic examination for prostate cancer for men age 50 and older, or age 40 and older with family history of prostate cancer.
WV	§§ 33-15-15 (indiv.); 33-16C-4 (group)	Medical and laboratory services for annual checkup for prostate cancer for men age 50 and over.

MANDATED BENEFITS:
HEALTH EXAMINATION BENEFITS, WELL BABY CARE

STATE	CITATION	SUMMARY
AR	§ 23-79-141	Mandated offering of coverage for routine periodic physical examination to age 16, copayments and deductibles no larger than for other office visits.
CA	§§ 10123.5 (group); 11512.17 (nonprofit hospital service plan)	Mandated coverage consistent with recommendation of American Academy of Pediatrics for physical examinations through age 16; mandated offering for ages 17-18.
CT	§ 38a-535	Mandated coverage of preventive pediatric care consistent with coverage provided for other services, through age 6.
DE	tit. 18 § 3335(b)	Mandated benefit for routine care, from birth.
DC	§ 35-1102	Mandated benefit for preventive care services; unlimited visits to age 12; 3 per year for children 12-18.
FL	§§ 627.6416, 627.6579; BULLETIN 87-205	Mandated coverage for health supervision services, exempt from deductibles, to age 16.

STATE	CITATION	SUMMARY
GA	§§ 33-30-4.5 (group) 33-29-3.4 (indiv.)	Mandated benefit for periodic review of child's physical and emotional status, including immunizations, from birth through age 5. No deductibles, commissioner may provide exclusions or coinsurance amounts.
HI	§§ 431:10A-115.5, 431:10A-206.5, 432:1-602.5	Mandated benefit for health supervision services, exempt from deductibles, through age 5.
IA	Reg. 191-80.1 to 191-80.5	Preventive services from birth through age 7 are mandated for group policies. No deductibles.
KS	§ 40-2,102	Mandated coverage for immunizations to age 5.
LA	§ 22:215.14	Mandated coverage for immunizations to age 6.
MD	art. 48A §§ 354KK, 470AA, 477KK	Requires coverage of specified list of services.
MA	§ ch. 175:47C	Mandated benefits for preventive care services to age 6.
MN	§ 62A.047	Mandated benefit for child health supervision services to age 6. Exempt from deductibles, copayments and dollar limitations.

STATE	CITATION	SUMMARY
MO	§ 376.801	Mandated offer of benefits for child health supervision services through age 12. Same deductible and coinsurance as other covered services.
MT	§§ 33-22-303 (indiv.); 33-22-512 (group); 33-30-1014 (nonprofits); Reg. 6.6.2508 (HMOs)	Mandated coverage through age 2 for all health insurers, HMOs and health service corps. Services must include well-patient exams.
NJ	17B:27-26-1h (group); 17B:26-2.1h (indiv.); 17:48E-35.6 (nonprofits); 17:48-6i (nonprofits)	Mandated offer of various benefits specified.
NM	Reg. 59A-46-1-C (HMOS) §§ 59A-22-34.3; 59A-23B-3; 59A-46-38.2	Well child care from birth. Childhood immunizations, including booster doses, as recommended by American Academy of Pediatrics, shall be covered subject to deductibles and coinsurance under the policy.

STATE	CITATION	SUMMARY
NY	§§ 3216(i)(17)	Mandated coverage of preventive and primary care services to age 19, not subject to deductibles and coinsurance.
OH	§§ 3923.55 to 3923.56	Mandated benefit for health supervision services to age 9. Subject to reasonable coinsurance and deductibles. Benefits limited to $500 first year of child's life, $150 per year thereafter.
OK	tit. 36 §§ 3201 to 3203	Must offer coverage for health supervision services through age 18.
PA	§§ 40-39-321 to 40-39-328	Requires coverage for child immunization. Coinsurance provisions apply same as other services, exempt from deductibles.
RI	§§ 27-38.1-1 to 29-38.1-3	Mandated benefit for pediatric preventative care to age 19, copayments no larger than other covered services.
UT	R590-76-4 (HMOs)	Well child care included in basic services offered by HMOs.
VA	§ 38.2-3411.1 Reg. 28 § 10 (HMOs)	Mandated offer of health supervision coverage through age 6. Not subject to coinsurance and deductibles. Well child care is a part of basic health care services required to be provided by HMO.

STATE	CITATION	SUMMARY
WV	§§ 33-15-15 (indiv); 33-16-12 (group); 33-16A-15 (group conversation); 33-25A-8c (HMOs)	Child immunizations covered without coinsurance or deductible.

MANDATED BENEFITS:
IN VITRO FERTILIZATION

STATE	CITATION	SUMMARY
AR	§§ 23-85-137 (indiv.); 23-86-118 (group)	Requires all disability insurers to include in vitro fertilization as a covered expense.
	Regulation 1	Sets minimum and maximum benefit levels; sets standards and guidelines for determining if policy must include in vitro fertilization coverage.
CA	§§ 10119.6 (insurers); 11512.28 (nonprofits)	Mandated offering of coverage for infertility treatment other than in vitro fertilization.
CT	§ 38a-536 (group)	Mandated offering to groups; coverage for necessary treatments for infertility including in vitro fertilization procedures.
HI	§§ 431, 433	Provides one-time only benefit for outpatient in vitro fertilization expenses; sets forth conditions for coverage; applies to all individual and group health policies and hospital or medical service plan contracts.

STATE	CITATION	SUMMARY
IL	215 ILCS 5/356m (group)	Group policies that cover pregnancy-related care must also cover infertility services, including in vitro fertilization.
MD	48A § 354DD (nonprofit health service plans); 48A § 470W (hospital or major medical coverage); 48A § 477EE (group/blanket coverage)	Provides that a health insurance policy issued on an expense-incurred basis that provide pregnancy-related benefits cannot exclude outpatient benefits for all outpatient expenses arising from in vitro fertilization procedures, lists conditions for coverage; applies to all policies covering residents who work within the state.
TX	art. 3.51-6 (1987)	All insurers, including HMOs and self-insurers, that provide hospital surgical and medical insurance with pregnancy-related benefits shall provide benefits, on an expense-incurred basis, for in vitro fertilization subject to certain conditions.

MANDATED BENEFITS:
RECONSTRUCTIVE SURGERY

STATE	CITATION	COVERAGE
AR	§ 20-1402 (group)	If cover mastectomy, cover reconstructive surgery incidental to covered mastectomy.
CA	§§ 10123.8 (group); 10123.82	If cover mastectomy, cover prosthesis or reconstructive surgery to restore symmetry.
CT	§§ 38a-503 (indiv.); 38a-542 (group)	If cover removal of tumors, cover reconstructive surgery or prosthesis. Must include reconstructive surgery on breast on which mastectomy was performed and reconstructive surgery on nondiseased breast to produce a symmetrical appearance.
FL	§ 627.6417 (indiv.); § 627.6612 (group)	Must provide coverage for prosthetic devices and breast reconstructive surgery incident to a mastectomy, including to reestablish symmetry between the two breasts.
IL	215 ILCS 5/356g	If cover mastectomy, cover prosthetic device or reconstructive surgery incidental to mastectomy.

STATE	CITATION	COVERAGE
LA	§ 22:215.18	If cover mastectomy surgery, must provide coverage for reconstruction of the breast on which surgery was performed and reconstruction of the other breast to produce a symmetrical appearance. Applies to policies issued on or after 1/1/98.
ME	24-A § 2731-A 24-A § 2745-C (indiv.); 24-A § 2837-C (group); 24-A § 4237 (HMOs; 24-A § 2320-C (nonprofits)	Mastectomy defined to include surgery to reconstruct breast on which surgery has been performed. Must include coverage of construction of both breasts to produce symmetrical appearance.
MD	48A § 490FF	All insurers, including HMOs, shall provide coverage for reconstructive breast surgery resulting from mastectomy. Shall include reconstructive surgery on nondiseased breast to achieve symmetry.

STATE	CITATION	COVERAGE
MI	§§ 500.3406a; 500.1415 (nonprofits); 500.3613 (group)	Reasonable charges for medical care and reconstructive surgery shall be covered.
MN	§ 62A.25	Cover reconstructive surgery following surgery or illness of the involved part.
MO	§§ 376.1209	If cover mastectomy, must provide coverage for prosthetic device or reconstructive surgery necessary to restore symmetry.
NV	§§ 689A.041 (indiv.); 689B.0375 (group); 695B.191 (nonprofits)	Cover reconstructive breast surgery if cover mastectomy; includes surgery on one or both breasts to reestablish symmetry.
NH	§ 417-D:2-b	If insurer covers mastectomy surgery, must also cover reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance.

STATE	CITATION	COVERAGE
NJ	§§ 17B:27-46.1a (group); 17:48-6b (hospital serv. corp.); 17B:26-2.1a (indiv.); 17:48A-7b (med. serv. corp); 17:48E-35 (health service corp.)	Following mastectomy, must cover reconstructive surgery, including surgery to restore and achieve symmetry and costs of prostheses or radiation then also cover cost of chemotherapy in connection with treatment of breast cancer.
NY	§ 3216(i)(20)	All comprehensive policies must include coverage for reconstructive breast surgery resulting from mastectomy. Shall include reconstructive surgery on nondiseased breast to achieve symmetry.
NC	§§ 58-51-61, 58-65-96, 58-67-79	Eff. 1/1/98 every policy issued or renewed that covers mastectomy must provide coverage for reconstructive breast surgery resulting from a mastectomy. Must include surgery on non-diseased breast to achieve symmetry.
PA	§ 40-39-125	A health policy covering a mastectomy must also include coverage for prosthetic devices and reconstructive surgery incident to the mastectomy, subject to usual coinsurance and deductibles. Coverage may be limited to surgical procedures performed within six years of the mastectomy.

STATE	CITATION	COVERAGE
RI	§§ 27-18-39 (ind. or group); 27-19-34 (nonprofits); 27-20-21 (nonprofits); 27-41-43 (HMOs)	Coverage for mastectomy shall include coverage for prosthetic devices and reconstructive surgery to restore symmetry. Reconstructive surgery must be performed within 18 months of the original mastectomy.
TN	HB 697 (1997)	A group or individual policy that covers mastectomy surgery must also provide for reconstructive breast surgery on diseased breast as well as any surgical procedure on non-diseased breast to achieve symmetry.
TX	§ 21.53D	If cover mastectomy, must cover reconstruction but may be subject to same deductible and copay as mastectomy.
WA	§§ 48.20.395; 48.21.230 (group)	Cover reconstructive breast surgery resulting from mastectomy, including breast reduction of nondiseased breast to make it equal in size after reconstructive surgery on diseased breast is performed.
WI	§ 632.895 (13)	If cover mastectomy, provide coverage for breast reconstruction of the affected tissue.

MANDATED BENEFITS:
TEMPOROMANDIBULAR JOINT DISORDERS (TMJ)

STATE	CITATION	SUMMARY
AR	Bulletin 11-84	TMJ treated as any other illness or injury and not considered dental work.
GA	§§ 33-29-20 (indiv.); 33-30-14 (group)	May not exclude treatment by physicians or dentists.
KY	§ 304.17-319	Cover all bones and joints if policy covers any.
MN	§ 62A.043	Policies other than specified disease policies must specifically provide coverage for TMJ and craniomandibular disorder.
MS	§ 83-9-45	Must offer coverage, same level as for any other joint in the body.
NV	§§ 689.A.0465; 689B.0739 (group); 695B.1931 (nonprofits); 695C.1755 (HMOs)	Health policy shall cover the temporomandibular joint.

STATE	CITATION	SUMMARY
NM	§ 59A-16-13.1	Policies other than specified disease policies must specifically provide coverage for TMJ and craniomandibular disorder.
NC	11 NCAC 12.0552 § 58-3-121	Policies providing surgical, medical and in-hospital benefits may not exclude coverage for TMJ caused by disease or accident, prosthesis placed directly on teeth may be excluded. If pay for any procedures involving bones or joints, may not exclude same coverage for procedures involving bones and joints of face.
ND	§ 26.1-36.09.3	Mandates coverage for TMJ and craniomandibular disorder; $10,000 maximum for surgery, $2500 maximum for non-surgical treatment.
TX	art. 21.53A	If provide coverage for treatment of skeletal joints, provide comparable benefits for TMJ.
VT	Bulletin 63	All insurers writing health insurance will honor claims for treatment of temporomandibular joint syndrome.
VA	§ 38.2-3418.2	If provide coverage for treatment of skeletal joints, provide comparable benefits for TMJ.

STATE	CITATION	SUMMARY
WA	§§ 48.21.320 (group); 48.33.460 (nonprofits); 48.46.530 (HMOs)	Optional coverage for TMJ disorders.
WI	§ 632.895 (11)	Required coverage for TMJ disorders.
WV	§ 33-16-3f; Reg. 114-29	Mandated offering of coverage for temporomandibular disorders and craniomandibular disorders. May decline coverage by written waiver.

MANDATED BENEFITS:
MISCELLANEOUS MANDATES:

STATE	CITATION	SUMMARY
	ALZHEIMER'S	
MD	48A § 477GG (group); 48A § 354FF (nonprofits)	Mandated offering of coverage for care of Alzheimer's, including nursing home care.
	AUTISM	
CO	§ 10-16-104.5	Autism is not a mental illness; cover same as any other sickness.
NH	§ 417-E:1	Cover "biologically based" mental illness, including autism, same as any other type of physical illness.
	OFF-LABEL DRUG USE	
MA	ch.175:47O to 175:47P; 176B:4P (nonprofits); 176G:4G (HMOs)	Off-label drugs for AIDS treatment must be covered.

STATE	CITATION	SUMMARY
	WIGS	
MN	§ 62A.28	Scalp hair prosthesis for hair loss suffered because of alopecia areata.
NH	§ 415:18-d (group)	Scalp hair prosthesis for hair loss suffered because of alopecia areata, alopecia totalis or permanent loss due to injury. Need statement from doctor that medical necessity.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Every effort has been made to provide correct and accurate summaries to assist the reader in targeting useful information. For further details, the statutes and regulations cited should be consulted.

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